Cambridge Health Alliance
A COMMUNITY OF CARING

WOMEN HEALTH
61746

THE CAMBRIDGE HEALTH ALLIANCE
AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Request for Copies of Medical Records X Request to Review Medical Records ____

Medical Record # 517999

Patient Name: BENITEZ (Last) FIAVIA (First) ____ (Middle)

Home Address: 122 WAIFORD WAY

State: BOSTON ZIP: 02129

Home Telephone: (508) 345-5380 Date of Birth: 10/05/54

I authorize (name of hospital/person) CAMBRIDGE HEALTH to: ☐ Obtain from ☒ Disclose to ☐ Communicate with

Name/Facility: COOLEY MANION JONES

Address: 21 CUSTOM HOUSE ST.

State: Boston ZIP: 02110 Phone: ____ Fax: ____

Attention: ____

Disclose the following information for treatment dates 5/26/01 to PRESENT

☐ Entire Medical Record OR

☐ Face Sheet ☐ Admission Note ☐ History & Physical ☐ Progress Notes

☒ Consults ☒ Lab Reports ☐ Pathology Reports ☒ X-ray/Scan/Imaging Reports

☒ Operative Reports ☒ Emergency Reports ☐ Physical Therapy Notes ☐ Clinic Notes

☒ Medication Notes ☐ Treatment Plan ☐ Discharge Summary

☐ Abstract (Discharge Summary, History & Physical, Operative, Pathology & Test Reports)

☐ Other NONE

The purpose of this disclosure is: ☐ Medical Care ☒ Legal Matter ☐ Insurance ☒ Personal

☐ Other ____

TERM: This Authorization expires /terminates/ends:

☐ 90 days from the date signed ☒ On Other date, reason or event 10 days 6/23/06

By my signature below, I hereby authorize Cambridge Health Alliance to obtain, use and/or disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

I understand that once Cambridge Health Alliance discloses my health information to the recipient, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Cambridge Health Alliance's treatment of me; except, however, if my treatment at Cambridge Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Cambridge Health Alliance may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cambridge Health Alliance's Privacy Office at the address listed below. The revocation will be effective immediately upon Cambridge Health Alliance's receipt of my written notice, except that